

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>004972</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>07/22/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>FRANCISCAN ST FRANCIS HEALTH - INDIANAPOLIS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>8111 S EMERSON AVE INDIANAPOLIS, IN 46237</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for a licensure complaint investigation.</p> <p>Complaint #IN00126476 Substantiated, no deficiencies related to allegations are cited.</p> <p>Date of Survey: 07-22-13</p> <p>Facility number: 004972</p> <p>Surveyor: John Lee, R.N. Public Health Nurse Surveyor</p> <p>Franciscan St Francis Health - Indianapolis is in compliance with 410 IAC 15-1.5-6, Nursing service, and 410 IAC 15-1.5-7, Pharmaceutical services, Hospital Licensure Rules.</p> <p>QA: cloughlin 8/14/13</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE